STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445478	A. BUILDING 01 -MAIN BUILDING 01 B. WING	01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM-HENSLEY HEALTH AND REHABILITATION	55 NURSING HOME RD CHUCKEY, TN 37641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with % hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to have self-closing doors to hazardous areas. The findings include: Observation on January 5, 2015 between 11:15 a.m. and 12:00 p.m. revealed the following hazardous area locations did not have self-closing doors: 1. Central supply room. 2. Dry storage in dietary. 3. General storage room off of the dietary manager's office. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on January 5, 2015.	K029	K-029 **Corrective Action for Targeted Area** On 1/13/15 the Maintenance Director installed door closers on doors in the central supply room, Dry storage in dietary, and general storage room off of the dietary manager's office. **Identification of Area with Potential to be affected** On 1/7/15 the Maintenance Director inspected other hazardous area location and found no other areas had been affected. **Systematic Changes** Measures to assure compliance include a quarterly audit of doors located in hazardous locations to ensure there is a door closer applied and it is working properly. **Monitoring** Results of these audits will be reported quarterly by the Maintenance Director to the performance improvement committee for review and recommendations. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist. The committee's recommendations will be followed up on by the Administrator and the Maintenance Director.	01-23-2015
K 038 SS F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathie H Ball
TITLE: Administrator
(X6) DATE: 1-16-15

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be excused from correcting providing it is determined tha other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JAN 22 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445478	A. BUILDING 01 -MAIN BUILDING 01 B. WING	01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM-HENSLEY HEALTH AND REHABILITATION	55 NURSING HOME RD CHUCKEY, TN 37641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 1 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to have delayed egress signage on a contrasting background. The findings include: Observation on January 5, 2015 at 11:10 a.m. revealed 7 of 7 delayed egress doors did not have the lettering of the delayed egress signage on a contrasting background. The lettering is placed on a clear glass door. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on January 5, 2015. NFPA 101 7.2.1.6.1(d)	K038	K-038 **Corrective Action for Targeted Area** On 1/7/15 the Maintenance Director installed new signage on 7 delayed egress doors that has a contrasting background. **Identification of Area with Potential to be affected** On 1/7/15 the Maintenance Director inspected egress doors and found that no other areas were affected. **Systematic Changes** Measures to assure compliance include a quarterly audit of egress doors by the maintenance director to ensure that they have signage that includes contrasting background. **Monitoring** Results of these audits will be reported quarterly by the Maintenance Director to the performance improvement committee for review and recommendations. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist. The committee's recommendations will be followed up on by the Administrator and the Maintenance Director.	01-23-2015
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation. it was determined that the facility failed to install fire dampers in the proper orientation.			

JAN 22 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445478	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM-HENSLEY HEALTH AND REHABILITATION	55 NURSING HOME RD CHUCKEY, TN 37641

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 2 The findings including: Observation on January 5, 2015 at 11:30 a.m. revealed in Zones 8, 9, 10 and 11, the ceiling radiant fire dampers were installed upside down having the blades of the dire damper and fusible link located at the bottom. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on January 5, 2015. NFPA 90A 3-4.6.2*	K067	K-067 **Corrective Action for Targeted Area** On 1/23/15 contracted HVAC company will reinstall ceiling fire dampers in zones 8,9,10, and 11 so the fusible link and damper blades are located at the top of the damper. **Identification of Area with Potential to be affected** On 1/7/15 the Maintenance Director inspected other areas with ceiling radiant fire dampers and found no other areas affected. **Systematic Changes** The Maintenance Director will audit the fire dampers annually to ensure that they are installed per the manufactures recommendation. **Monitoring** Results of the reports will be reported by the Maintenance Director annually to the performance improvement committee for review and recommendations. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist. The committee's recommendations will be followed up on by the Administrator and the Maintenance Director.	01-23-2015

JAN 22 2015